

# 2004 Epidemiologic Profiles of HIV/AIDS in Michigan

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# 2004 Epidemiologic Profiles of HIV/AIDS in Michigan

## Executive Summary

At the end of 2003, a total of 11,527 persons were known to be living with HIV/AIDS in Michigan, nearly half (48 percent) of whom had a diagnosis of AIDS. Currently, there are persons living with HIV in all but 3 counties in the state, and the number continues to increase each year. Declines in the number of deaths of persons with AIDS since 1995 were caused primarily by the slower progression of HIV-associated immune deficiency among persons who used highly active antiretroviral therapy (HAART).

HIV disease is distributed disproportionately in Michigan. Most HIV/AIDS cases continue to be diagnosed in the Detroit Metropolitan Area, where 45 percent of the state's population lives, but where two-thirds (67 percent) of all persons currently living with HIV in Michigan reside. HIV positive residents of this area continue to be predominantly men who have sex with men, black, and ages 25-44 years old at time of diagnosis.

The proportion of persons diagnosed each year with HIV between 1998 and 2002 has not changed significantly for any race/sex group. Although the trend in new HIV infections among blacks is level, this group is still impacted disproportionately compared to the general population. Black males and females make up 14 percent of the general population in Michigan, but 58 percent of persons living with HIV/AIDS. The rate of HIV infection is currently 8.5 times higher in the black population than in the white population.

Among men in all racial groups, male-male sex is the predominant mode of exposure. For women in all racial groups, high-risk heterosexual sex is the predominant mode of exposure. However, injection drug use is still a concern for both sexes. Since 1998, however, the number of cases among injecting drug users has declined substantially.

# 2004 Epidemiologic Profiles of HIV/AIDS in Michigan

## Introduction

This year the HIV/STD & Bloodborne Infections Surveillance Section is providing prevention and care planning groups with the epidemiologic profiles for the State of Michigan, the Detroit Metropolitan Area, and Out-State Michigan (including the upper peninsula and the balance of the lower peninsula). The profiles use a simplified method of ranking the priority of behavioral groups. The rank was based on the percentage of total reported HIV/AIDS cases for each behavioral group.

In order to measure prevention achievements, the number of persons who become newly infected would ideally be followed over time. Methods for measuring new infections are currently being developed, however, since surveillance is not yet able to do this, trends are analyzed among those newly diagnosed with HIV disease between 1998 and 2002. In addition, the HIV/STD & Bloodborne Infections Surveillance Section will continue to track trends for AIDS cases since these trends measure changes in treatment effectiveness and access to care.

The HIV/STD & Bloodborne Infections Surveillance Section creates these profiles every other year, however, statewide and some county statistical analyses are created and disseminated on a quarterly basis. When reading either of these documents, the reader must keep in mind that they are based on two different populations. The HIV/AIDS Quarterly Analyses use cases of HIV/AIDS whose **residence at diagnosis** was Michigan (cases that were diagnosed in Michigan can presently be living elsewhere). The Epidemiologic Profiles of HIV/AIDS in Michigan use cases of HIV/AIDS that are **currently living** in Michigan. There are 382 more persons included when we use the HIV infected population **currently living** in Michigan. The reason for this difference is to satisfy questions on both populations. Therefore, there may be differences in numbers, percents, and rates when comparing the two documents.

In 2003, the Centers for Disease Control and Prevention (CDC) developed guidelines to help in the creation of the profiles. The purpose was to facilitate combining Care and Prevention information nationally. Michigan has been creating a combined Care and Prevention Profile since 1998. This year, we have followed these guidelines where information was available and time allowed for thoughtful integration. They will be incorporated more fully in the next publication (Profiles 2006).

There are many new additions to the profiles this year, we have increased the number of data sources and provided a detailed description of each one. We have provided a listing of all tables and figures, and finally, we are providing a feedback form in order to evaluate our efforts in serving the consumers of the profiles. Ideas on ways to improve the profiles are always welcome.

Staff from the MDCH HIV/STD & Bloodborne Infections Surveillance Section are available to assist in interpretation of these profiles as well as to provide additional analyses. Questions or comments about these profiles should be either returned using the feedback form, or directed to your county contacts. With your assistance, surveillance data will continue to guide HIV prevention strategies and resource allocation for care services in Michigan. For the statewide and Out-State profiles, please call (517) 335-8165. For the statewide and Detroit Metro Area profiles, please call (313) 876-0353.

# 2004 Epidemiologic Profiles of HIV/AIDS in Michigan

## Profiles Strengths and Limitations

When making planning decisions, it is important to consider the overall strengths and limitations of this document. Although the profile is comprehensive and draws from a number of data sources, there are many things that the profile cannot explain.

Although the HIV/AIDS surveillance system in Michigan is extensive, it is based on data on people who have been tested confidentially for HIV. Consequently, infected persons who have not been tested, are tested anonymously, or are tested by name but not reported are not included. Therefore, HIV infections are under-detected and underreported. However, HIV/AIDS Surveillance data are considered to be among the most complete, compared with other notifiable diseases and infections. In order to compensate for these uncounted infections, estimates are provided in several tables.

The data presented in this report do not necessarily represent the characteristics of persons who have been recently infected with HIV, nor do they provide a true measure of HIV incidence because persons are tested at differing times after they become infected, and many persons are not tested until HIV infection has progressed to AIDS.

Analyses of many different data sets are presented to provide robust representations of particular subpopulations. However, demographic and geographic subpopulations are disproportionately sensitive to differences and changes in access to health care, HIV testing patterns, and specific prevention programs and services. All of these issues must be carefully considered when interpreting HIV data. Therefore, it is important to make comparisons across data sources to get the most complete picture.

The most current analysis available is presented for each source of data; however, the most recent data differ from one source to another. For example, the most recent data available for SHAS are from 2003, whereas some data (e.g., CITY) were collected in 1999. In addition, more detailed analyses are available for some sources. The information in this report is for statewide planning, but some local data are presented.

# 2004 Epidemiologic Profiles of HIV/AIDS in Michigan

## Data Sources

Data were compiled from a variety of sources to provide the most complete picture possible. When interpreting the data, keep in mind that each of the data sources has strengths and limitations. A brief description of each of the data sources follows.

### Core HIV/AIDS Surveillance

#### *HIV/AIDS Surveillance Data*

In 1983, the Michigan Department of Community Health (MDCH) established a surveillance system to track newly diagnosed AIDS cases. This surveillance system was expanded in 1989 to include confidential name-based HIV reporting. Standardized case report forms are used to collect sociodemographic information, mode of exposure, laboratory and clinical information, vital status (i.e., living or dead), and referrals for treatment or services. HIV surveillance data may underestimate the number of recently infected persons because some infected persons either have not been tested or have been tested, but not yet reported to MDCH. Persons who tested positive at an anonymous test site and have not sought medical care (where they would probably be confidentially tested) are not included in HIV surveillance statistics because cases without names cannot be unduplicated. Therefore, HIV infection data provide minimum estimates of the number of persons known to be HIV infected. In addition, newly diagnosed cases may be reported to the health department at any point along the clinical spectrum of disease. Consequently, HIV infection data do not necessarily represent characteristics of persons who have been recently infected with HIV. In order to provide a more concise measure of the impact of HIV, MDCH provides an estimate of the prevalence of HIV. This estimate includes measures of those HIV infected individuals who have been tested, but not reported to the health department, as well as those HIV infected individuals who have not yet been diagnosed and represents all infected persons regardless of whether they have been tested or reported.

### Supplemental HIV/AIDS Surveillance Projects

#### *Adult/Adolescent Spectrum of HIV Disease (ASD) Study*

The Adult/Adolescent Spectrum of Disease (ASD) was a multi-site national surveillance project sponsored by the Centers for Disease Control and Prevention (CDC). ASD collected data in six-month follow-up intervals from the medical records of HIV-infected persons in care, from the time they first contacted an ASD site until they died or were lost to follow-up. The behaviors reported by these interviewed individuals may differ from those who do not report for care or are uninfected. Michigan ASD includes data on a representative sample of HIV-infected persons who presented for care at the Henry Ford Health System, Detroit campus (HFHS) or at the Detroit Medical Center (DMC). Michigan participated in ASD from its inception in 1990 through its closure in 2004. More than 5500 patients were enrolled in Michigan ASD, and at the end of the project 2667 patients had died, 1492 had moved or were otherwise lost to follow-up, and 1392 were still living. ASD collected data on demographics, opportunistic illnesses, other infections such as Hepatitis B and C, other conditions such as depression and hypertension, CD4<sup>+</sup> T-cell counts, viral load measurements, prescription of medications, substance abuse, mental illness, and many other variables. Although data collection for ASD will be complete by the end of 2004, analyses of the ASD database are in progress and will continue for at least the next two years. Understanding the specific behaviors of infected persons can help with understanding risk and make for a more targeted prevention intervention.

# 2004 Epidemiologic Profiles of HIV/AIDS in Michigan

## Data Sources (Continued)

### *Supplement to HIV/AIDS Surveillance (SHAS) Project*

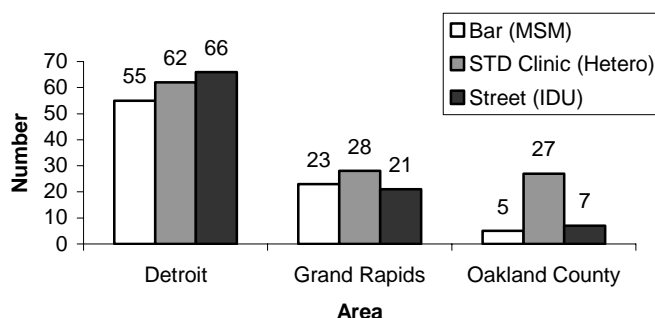
Supplement to HIV/AIDS Surveillance is a one-time, cross-sectional interview project that collected self-reported behavioral information from individuals infected with HIV and/or AIDS who present for care. The behaviors reported by these interviewed individuals may differ from those who do not report for care or are uninfected. Data have been collected since 1990 among persons 18 years of age and older. Individuals who present for care at one of three entities at five Detroit locations - two large tertiary medical centers, two neighborhood clinic systems, and one health care center are eligible for an interview. Data were collected on demographic and socioeconomic factors, drug use (alcohol, ingested and/or injected drugs), needle sharing and cleaning, access to drug treatment, sexual behaviors, condom use, medical and social services, compliance with drug therapies, and, for women, reproductive history and child health. SHAS data are useful for informing health department policymakers, HIV community planning groups, and enhancing public health prevention programs and services. Understanding the specific behaviors of infected persons can help with understanding risk and make for a more targeted prevention intervention. Prevention and care planning groups are encouraged to contact the MDCH HIV/STD & Bloodborne Infections Surveillance Section for additional data from this project. Summaries of the 1990-2000 SHAS data (2,205 interviews) and 2000-2004 SHAS data (SHAS II, 1,174 interviews) are available on-line at: [www.michigan.gov/mdch](http://www.michigan.gov/mdch).

### *HIV Testing Survey (HITS)*

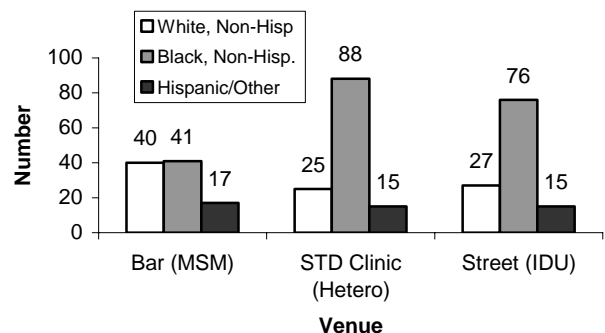
In 2002, as part of behavioral HIV/AIDS surveillance efforts, the Centers for Disease Control and Prevention (CDC) funded an interview survey for uninfected persons at risk of HIV, living in Michigan. This multi-site project, the HIV Testing Survey (HITS), was conducted in fifteen cities or states across the country, using a standard protocol that had been used successfully in other cities in the United States. In this state, the project was conducted in Detroit (183) and Oakland (Cities of Pontiac, Southfield, and Royal Oak, 39 surveys) and Kent (City of Grand Rapids, 72 surveys) counties. Data from these areas are left combined in the Detroit Metro Area and Out-State Michigan profiles to maintain statistical power.

The participants for this survey were recruited from three types of public venues: street locations for injection drug users (including needle exchange venues), public health sexually transmitted disease (STD) clinics for high-risk heterosexuals, and bars for men who have sex with men. Before the survey began formative research was conducted. The objectives of the formative research were to better understand the demographic characteristics of the populations at risk who were included in the study, and to identify the sites (i.e., clinics, bars, street settings) where the interviews were conducted.

**Geographic and Venue Breakdown of HITS**



**Race Breakdown for each Venue, HITS**



# 2004 Epidemiologic Profiles of HIV/AIDS in Michigan

## Data Sources (Continued)

### Behavioral Surveys

#### *Family of Seroprevalence Surveys*

The Family of HIV Seroprevalence Surveys monitored HIV prevalence among high-risk populations in southeastern Michigan. These surveys were administered from 1988 through 1999 in various public health clinics and facilities. Survey data were collected annually and consisted of demographics, sexual risk behaviors, clinical diagnosis, illicit drug use, and laboratory results. Data were abstracted from patient files and no additional information was asked for the purpose of the survey. The surveys were blinded. Only remnant sera from routine collected sera were tested for HIV antibodies after personal identifiers were removed. Data were used to monitor trends in HIV infection, assess changes in risk behaviors and assist in the planning and evaluation of prevention programs. These specimens were used in the early 2000s to estimate HIV incidence in selected populations by applying the STARHS algorithm to the stored specimens that were previously collected. (STARHS testing on unblinded routine specimens collected for HIV testing is scheduled to begin in late 2004).

#### *Community Intervention Trial for Youth (CITY)*

During the summer of 1999, the Center for AIDS Intervention Research at the Medical College of Wisconsin in collaboration with the Midwest AIDS Prevention Project conducted a survey in Milwaukee, Wisconsin and Detroit, Michigan. The survey was called the Community Intervention Trial for Youth (CITY) and aimed to collect baseline behavior data from young men who have sex with men. Men were randomly recruited outside of venues frequented by young men who have sex with men (i.e. bars, coffee shops, cruising areas). A total of 547 men were interviewed, 48.3% were from Detroit. The mean age was 21, with a range of 15 to 25 years old. Topics of interview questions were basic demographics, sexual identity, female partners, male partners (main and non-main), drug use, condom use, social support, anti-retroviral knowledge, and exposure to interventions.

#### *Job Corps*

Job Corps is a federally funded jobs training program for socially and economically disadvantaged out-of-school youth. This study sought to describe HIV infection demographic characteristics of youth, aged 16 through 21 years, who entered the U.S. Job Corps from January 1988 through December 1998. Nationally, 357,443 entrants residing at Job Corps centers during their training were tested for HIV infection. The results indicate that more than 2 per 1,000 were HIV-infected. From the beginning of the study period to the end, HIV prevalence among young people in the Job Corps was cut in half, however, rates of HIV infection among Job Corps participants are more than 2 times higher than rates among youth seen in adolescent health clinics and more than 8 times higher than among young people of the same age applying for military service. The system for collecting Job Corp data underwent numerous changes in the years after 1996 that precluded these types of analyses. A new system was implemented in 2002-2003. These data are currently being examined.

# 2004 Epidemiologic Profiles of HIV/AIDS in Michigan

## Data Sources (Continued)

### ***Youth Risk Behavior Survey (YRBS)***

The Youth Risk Behavior Survey (YRBS) is conducted every other year in Michigan and assesses a broad range of health practices among a representative sample of the state's students in grades 9 through 12. Data are weighted so that survey results can be generalized to all high school students in the state. Michigan is one of only a handful of states with high enough response rates on four consecutive YRBS survey administrations (1997, 1999, 2001 and 2003) to have scientific trend data. The YRBS collects information on six categories of behaviors related to the leading causes of mortality and morbidity among both youth and adults. Sexual behaviors that contribute to unintended pregnancy and STDs including HIV infection constitute one of the six categories. Questions in this category ask about HIV prevention education, sexual activity (age at initiation, number of partners, condom use, past drug or alcohol use, forced sex), contraceptive use, and pregnancy history. The YRBS is a standardized questionnaire, so comparisons can be made between states, participating cities, and the nation on core questions. States and cities may also add questions of local interest. Michigan has added two questions to the sexual behavior section: one on parent-child communication and the other on age of first sexual partner. Because the YRBS relies upon self-reported information, sensitive behavioral information may be underreported or over-reported. Also, because the YRBS questionnaire is administered in school, the data are representative only of adolescents who are enrolled in school and cannot be generalized to all adolescents. For example, students at highest risk, who may be more likely to be absent from school or to drop out of school, may be underrepresented in this survey, especially those in upper grades. The Michigan questionnaire does not include questions about sexual orientation or gender of sexual partner.

### ***The Bureau of Juvenile Justice Youth Risk Behavior Survey (YRBS)***

The BJJ Youth Risk Behavior Survey (BJJ YRBS) is an expansion of the Youth Risk Behavior Survey surveying effort that is conducted every other year in Michigan and assesses a broad range of health practices among a representative sample of the state's students in grades 9 through 12. The one time BJJ administration occurred was in the spring of 2002. Unlike the general education YRBS, which uses a two stage sampling process, the BJJ YRBS was a census of youth in state-operated residential Bureau of Juvenile Justice facilities (9 sites within 6 centers). A total of 470 youth were eligible to participate. All sites, centers, and classrooms participated. A total of 418 usable questionnaires were analyzed, for a final student participation rate of 89%. The results of the BJJ YRBS should be compared with the Michigan general education YRBS with caution because the students may not be comparable in age, race/ethnicity, and gender. However, the BJJ respondents were roughly the same age as their general education counterparts in grades 9-12, with 83% between the ages of 15 and 18. The BJJ used the core general education Michigan YRBS survey instrument with some questions omitted, added, and adapted to better meet the needs of the youth in the residential facilities. Questions assessing the incidence of risk behaviors "in the past 30 days," were modified to say, "in the 30 days before you entered the facility." The instrument included questions in all six categories of behaviors included on the main YRBS. Additional questions in the sexual behavior section assessed sexual orientation, gender of sexual partner, and history of HIV testing. The survey provides a picture of the behaviors of a sub-population of youth who are at considerably greater risk than their counterparts in school.



# 2004 Epidemiologic Profiles of HIV/AIDS in Michigan

## Data Sources (Continued)

### Communicable Disease Surveillance

#### *TB Registry*

All TB cases reported in the State of Michigan are reported using the CDC Report of a Verified Case of Tuberculosis (RVCT) form. Surveillance information and laboratory reports on active TB cases and TB suspects are maintained in the Tuberculosis Information Management System (TIMS) database. Surveillance data are analyzed to monitor statewide tuberculosis trends, including HIV/TB co-infection, as well as to determine appropriate treatment regimen, drug susceptibility results and completion of TB therapy status. TIMS is also currently utilized to report the State's verified TB cases to the Centers for Disease Control and Prevention (CDC). Each year, the TB registry is matched to the HIV/AIDS surveillance data. Outcomes from the match include documenting progression from HIV to AIDS, completing TB infections reported directly to HIV surveillance and, occasionally, new HIV cases.

#### *STD Reporting System*

The Michigan Department of Community Health, Division of HIV/AIDS and STD conducts statewide surveillance to determine the number of reported cases of STDs, monitor trends, provide partner counseling, and referral services for examination and treatment. All of these objectives aim at reducing the spread of STDs in the community. In Michigan, gonorrhea, chlamydia, syphilis, lymphogranuloma venereum, chancroid, and granuloma inguinale are reportable by physicians and laboratories. There are significant variations in the completeness of data coming from public and private providers. Approximately 77% of female cases and 49% of male cases come from private providers. Among public providers, only 10% of race data is missing. However, 63% of race data is missing in reports from private providers. Gonorrhea is the third most frequently reported communicable disease in Michigan, while chlamydia is the second most frequently reported, second only to influenza-like-illness. Michigan does not collect standardized sexual orientation data or site of specimen (pharyngeal, rectal, genital) for gonorrhea or chlamydia cases. However, these data are collected for syphilis cases. For data on STD cases in Michigan, by age, race, and sex, please refer to [http://www.mdch.state.mi.us/PHA/OSR/chi/std\\_h/frame.html](http://www.mdch.state.mi.us/PHA/OSR/chi/std_h/frame.html)

### Vital Statistics Data

#### *Birth and Death Data*

The National Center for Health Statistics receives information on births and deaths in the United States through a program of voluntary cooperation with state government agencies (i.e., state departments of health, state offices of vital statistics) called the Vital Statistics Cooperative Program. States use standard forms to collect birth and death data. The birth certificate form includes demographic information on the newborn and the parents, insurance status, prenatal care, prenatal risk factors, maternal morbidity, mode of delivery, pregnancy history, and clinical characteristics of the newborn. Death certificates include demographics, underlying cause of death, and contributions of selected factors to the death (i.e., smoking, accident, or injury) of all deceased persons. Reporting is virtually 100% complete for births and deaths. Therefore, inferences can be made concerning the number of live births in a service area. The data can also be used to determine the effect of deaths related to HIV infection in a service area. The data on birth certificates that are obtained from patient medical records (i.e., smoking history, morbidity) may be incomplete. In addition, deaths resulting from, or whose underlying cause was, HIV infection may be underreported on a death certificate. Clinical information related to HIV or AIDS may be missing.

# 2004 Epidemiologic Profiles of HIV/AIDS in Michigan

## Data Sources (Continued)

### Population Data

#### ***U.S. Bureau of the Census (Census Bureau)***

The Census Bureau collects and provides timely information about the people and economy of the United States every 10 years. The Census Bureau's Web site (<http://www.census.gov>) includes data on demographic characteristics (e.g., age, race, Hispanic ethnicity, sex) of the population, family structure, educational attainment, income level, housing status, and the proportion of persons who live at or below the poverty level. Summaries of the most requested information for states and counties are provided, as well as analytical reports on population changes, age, race, family structure, and apportionment. State- and county-specific data are easily accessible, and links to other Web sites with census information are included. The Michigan-specific Census data used in these profiles was obtained using the American Fact Finder (<http://www.census.gov/main/www/cen2000.html>), supported by the U.S. Census Bureau. This website is a user-friendly way to obtain Census data. The data used in these profiles are from the 2000 census.

### Ryan White CARE Act Data

#### ***Ryan White CARE Act Data: The State of Michigan Uniform Reporting System Data Collection Process***

The Michigan Department of Community Health (MDCH), Division HIV/AIDS-STD (DHAS), HIV/AIDS Prevention & Intervention Section (HAPIS), has had Title II Grantees to collect data for the current client-level Uniform Reporting System (URS) demonstration project in the state of Michigan for ten (10) years. Beginning in 1994, MDCH successfully collaborated with the HIV/AIDS Program of the City of Detroit Department of Health and Wellness Promotion (DHWP), the Title I Grantee, to establish a statewide client-level data system in the state and the Detroit Eligible Metropolitan Area (DEMA). Michigan's client-level data system currently encompasses all Title I and Title II providers in the state (including the Drug Assistance Program) as well as all Title IV-funded programs. In addition, three of the four service organizations funded through Title III collect and submit URS data. The Ryan White (RW) CARE Act was enacted in 1990 to provide medical and supportive services to low-income HIV positive individuals who are uninsured or under-insured. Clients may be eligible to receive RW services if they do not have another private or public source to provide those services. Eligible services may vary by jurisdiction, and may include primary out patient medical care, medications, case management, transportation, mental health services and other supportive services.

Client data are collected and entered into the electronic data collection tool program by the direct service worker. Annual client data elements are reviewed and updated at least once a year; quarterly data elements are entered each quarter. Service data are entered at least on a monthly basis or in "real time" as services take place. These electronic files contain descriptive and service data for each client served during the quarter and use the encrypted Unique Record Number (URN) as the only client identifier. The URS staff, for completeness and to ensure data consistency, generates a Quality Assurance Report and a Summary Report for each HIV service provider. The data are combined and unduplicated across all providers, using the data collection tool's unduplication module. The unduplicated statewide data file is exported and sent to Health Resources and Services Administration (HRSA) according to their established schedule. Reports are generated based on unduplicated statewide and local data. Reports and analyses are made available to providers and local consortia for planning and evaluation purposes.

# 2004 Epidemiologic Profiles of HIV/AIDS in Michigan

The Michigan Department of Community Health is constantly striving to deliver important and useful information to our wide array of consumers. To help us find out if we have served you adequately, please take a few moments to complete the survey below. Please answer 1 through 5 to best describe your experience (1 = Strongly Agree, 2 = Agree, 3 = Neither agree or disagree, 4 = Disagree, & 5 = Strongly Disagree). **See reverse side for mailing instructions.**

	<i>Example</i>	Forward	State of Michigan	Detroit Metro Area	Out-State Michigan
Language was clear and topics were adequately explained	1				
Use of numbers, percents, and rates were clear and appropriate	2				
Tables & Figures were easy to read and understand	1				
<b>Information about the following topics was adequately discussed:</b>					
Summary of the Epidemic	2				
Distribution of HIV/AIDS by Mode of Transmission	1				
Distribution of HIV/AIDS by Race and Sex	2				
Trends in HIV	2				
Use of Care Services	1				
Focus on Kent County	1				
Focus on Berrien County	1				
Sexually Transmitted Diseases	1				
HIV/Hepatitis Co-Infection	1				
HIV/TB Co-infection	1				
Male-Male Sex	1				
Injecting Drug Use	1				
Heterosexual Sex	1				
Race/Sex	2				
Children	1				
Teens and Young Adults	1				
50 Years and Older	2				
Rural Areas	2				
Arabic Populations	1				
Prison Populations	1				

Was there any grouping or population you would like to have seen discussed?

Other Comments:

# 2004 Epidemiologic Profiles of HIV/AIDS in Michigan

Thank you for taking the time to give us feedback on the 2004 Epidemiologic Profiles of HIV/AIDS in Michigan! Your comments will help us to make improvements for the next publication. Please tear out this form and return to the Michigan Department of Community Health.

## Instructions for mailing:

- If provided, please use the self-addressed, stamped envelope to return your form (envelopes were included in all printed copies).
- If there is no envelope, please tri-fold the form along the dotted lines (with the form-side in and address-side out), tape it closed, stamp, and mail.

“2004 Epidemiologic Profile Feedback Form”  
Michigan Department of Community Health  
3423 N. MLK Blvd, Room 302  
PO BOX 30195  
Lansing, MI 48909



“2004 Epidemiologic Profile Feedback Form”  
Attn: Elizabeth Hamilton, M.P.H.  
Michigan Department of Community Health  
3423 N. MLK Blvd, Room 302  
PO BOX 30195  
Lansing, MI 48909